nursing aides, orderlies, attendants, occupational therapists, speech therapists, recreational therapists, physical therapists, and respiratory therapists. Any personnel in these categories who are primarily conducting administrative job duties and are not directly involved with providing patient care are not eligible for CBC allowance.

(b) The CBC for reasonable increases in direct care staff salaries and wages is defined as the reasonable rate year wage rate less the inflated base year wage rate, times the lesser of the rate year FTE direct care labor force or the base year FTE direct care labor force.

(c) The inflation allowance for direct care staff includes the full amounts granted in Section III.B.3.

(d) The reasonable rate year wage is the level of increase required to attract sufficient staff to ensure minimum availability of care as determined by the Department of Public Health for current patients. The wage rate is determined with reference to average rates prevailing at other hospitals within the same Medicare labor market region, subject to the following conditions:

(i) Outlier wage rates are excluded from the computation;

(ii) Special weight is given to rates prevailing at non-acute hospitals located in the hospital's Medicare labor market region;

(iii) If it can be demonstrated that direct care staff at a hospital are transferring in significant numbers to another competing hospital, then the wage rates prevailing at that competing hospital are given special weight; and

(iv) In no case shall the reasonable rate year wage rate used in this calculation exceed the wage rate actually prevailing at hospitals located in the hospital's Medicare labor market region at the time of application.

(v) The determined Medicare Labor Market

Regions and their associated counties are as follows:

Medicare Labor Market Region	Counties
Eastern Mass	Bristol
	Essex
	Middlesex
	Norfolk
	Plymouth
	Suffolk
	Worcester
Berkshire	Berkshire
Springfield	Hampden
	Hampshire
Barnstable	Barnstable
	Dukes
	Nantucket
Rural	Franklin

(e) In order to be eligible for this exception, a hospital must demonstrate that it is facing extraordinary difficulties in the market for direct care staff, as indicated by one or more of the following criteria:

(i) existence of significant vacancy rates for a period of time sufficient to jeopardize the welfare of patients according to Department of Public Health standards, Joint Commission on Accreditation of Health Care Organizations standards or other qualifying guidelines utilized in Massachusetts to ensure adequate care;

(ii) persistent difficulty in recruitment given bona fide recruitment efforts to obtain staffing levels; and

(iii) existing dependency upon temporary nursing services in order to maintain staffing levels.

(8) A CBC is allowable for an increase in inpatient care costs generated by increased care or services required by a more intensely ill patient population. It is the hospital's burden to demonstrate a net increase in intensity from either the

base year or the last year for which a casemix adjustment was made (whichever was later).

(a) Psychiatric Hospitals may demonstrate that increases in certain intensity factors between the base year and the intermediate year have led to increases in service intensity e.g., FTEs, nursing hours per patient), which in turn have led to quantifiable increases in cost. Intensity factors include, changes in: age mix, average length of stay, number of involuntary lockup patients, patient disability index, and percentage of patients admitted from an acute hospital. Note that increases in inputs alone are not enough to qualify for an intensity CBC; some intensity-related change in patient characteristics must also be identified.

(b) If the documentation for the increase in intensity is found to be acceptable then the hospital shall have the burden of documenting the increase in patient care costs resulting from the higher level of intensity.

(9) Costs for increases in physician malpractice insurance premiums paid by the hospital for physicians who are employees of the hospital and who do not bill patients or third-party reimbursers separately for their professional services. The amount of the approved exception allowance will be the net of all the increases already determined through the inflation allowance for malpractice insurance premiums from the base year forward and included in the hospital's Medicaid rates. The hospital must document the actual malpractice insurance premium expense, as well as show that the physicians covered are employees of the hospital and do not bill separately for their services. The hospital may include in the CBC request the amount of any retroactive premium payments to be made during the rate year.

C. No costs other than those meeting the criteria set forth in one or more of the above categories constitute a cost beyond the reasonable control of the hospital.

6. New Services

Certain health services that were not offered by a hospital in the base year, meeting the data reporting and other requirements described in Section III.A herein, are included in the operating requirement as new services. The

allowable cost for a new service is equal to the reasonable operating costs attributed to the new service cost centers.

III.C. Determination of Capital Requirement:

The Capital Requirement consists of the sum of the allowed cost for depreciation on building and fixed equipment, plus the allowed cost for interest expenses, plus a return on base-year equity capital invested, as determined by the Principles of Reimbursement for Provider Costs under 42 U.S.C. ss. 1395 et seq. as set forth in 42 CFR 413 et seq. and the Provider Reimbursement Manual.

A non-state-owned psychiatric hospital's allowable capital requirement consists of the hospital's actual base year costs for historical depreciation for building and fixed equipment; reasonable interest expenses; amortization and; leases and rental of facilities. The capital requirement further includes incremental capital costs associated with approved CBCs and new services.

The base year capital requirement is further adjusted to include reasonable projected acquisitions and retirements of fixed equipment and plant, and reasonable projected increases and decreases in amortization, leases and rentals, subject to the limitations contained in 114.1 CMR 40.07(3).

III.D. Determination of Reasonable Financial Requirements (RFR) for the Rate Year:

Reasonable Financial Requirements (RFR) is equal the total of the Operating Requirement, determined according to Section III.B.2 herein, the Capital Requirement, determined according to Section III.C. herein, and a working capital requirement that is calculated by multiplying the sum of the operating requirement and the capital requirement by .0055.

III.E. Determination of Approved Gross Patient Service Revenue for the Rate Year:

A psychiatric hospital's GPSR is its the total dollar amount of its projected Charges for the rate year. In prior years, GPSR was approved by the DHCFP in accordance with the provisions of 114.1 CMR 40.04(4)(b).

III.F. New Hospitals

For new hospitals, which were not licensed and/or operated as psychiatric hospitals in RY 1997, or did not have a base year previously established, the Division may consider alternative data sources to determine Base Year costs. Criteria for such review will include but will not be limited to peer group analysis of costs incurred and the determination of approved rates for

comparable facilities

III.G. Rates of Payment for Medicaid Services

1. For all non-state-owned Psychiatric Hospital services, the Medicaid rate of payment is equal to the payment-on-account factor (PAF) multiplied by the Charge for each eligible service provided to a Recipient under the Medicaid program.

2. A non-State-owned psychiatric hospital's PAF is computed by dividing its approved RFR by its GPSR. For rate year 1998, the Division will establish the rate year 1998 PAF for psychiatric hospitals at the levels previously approved by the Division of Health Care Finance and Policy for RY 1997. The PAF shall not exceed 100%.

IV. Determination of Disproportionate Share Adjustments

The Medicaid program will assist hospitals which carry a disproportionate financial burden of caring for the uninsured and low income persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment to hospitals which qualify for such an adjustment. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating these adjustments are described in Sections V and VI below.

(1) To qualify for any type of disproportionate share payment adjustment, a hospital must have a Medicaid inpatient utilization rate (calculated by dividing Medicaid patient days by total patient days) of not less than 1%.

(2) The total of all disproportionate share payments awarded to a particular hospital under Section V. below shall not exceed the costs incurred during the year of furnishing hospital services to individuals who either are eligible for Medicaid or have no health insurance or source of third party coverage, less payments by Medicaid and by uninsured patients.

V. Federally Mandated Disproportionate Share Adjustments

(1) Data Sources. The Division shall determine for each fiscal year a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The prior year DHCFP-403 report is used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient net revenues, total inpatient charges and free care charge-offs. If said DHCFP-403 report is not available, the Division shall use the most recent available prior year DHCFP-403 report to estimate these variables.

(2) Determination of Eligibility Under the Medicaid Utilization Method. The Division

shall calculate a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of all non-acute care hospitals for the federally-mandated disproportionate share adjustment. The Division shall determine such threshold as follows:

(a) First, calculate the statewide weighted average Medicaid inpatient utilization rate by dividing the sum of Medicaid days for all non-acute care hospitals in the state by the sum of total inpatient days for all non-acute care hospitals in the state.

(b) Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.

(c) Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide weighted average Medicaid inpatient utilization rate. The sum of these two numbers is the threshold Medicaid inpatient utilization rate.

(d) The Division shall then calculate each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to Section V.(2)(c), then the hospital is eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

(3) Determination of Eligibility Under the Low-Income Utilization Rate Method.

The Division shall then calculate each hospital's low-income utilization rate. The Division shall make such determination as follows:

(a) First, calculate the Medicaid and subsidy share of net revenues by dividing the sum of Medicaid net revenues and state and local government subsidies by the sum of total net revenues and state and local government subsidies.

(b) Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of audited free care charge-offs by total inpatient charges.

(c) Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of net revenues calculated pursuant to Section V.(3)(a) to the free care percentage of total inpatient charges calculated pursuant to Section V.(3)(b). If the low-income utilization rate exceeds 25%, the hospital is eligible for the federally-mandated Medicaid disproportionate share adjustment under the low-income utilization rate method.

(4) Determination of Payment. The payment under the federally-mandated disproportionate share adjustment is calculated as follows:

(a) For each hospital determined eligible for the federally-mandated disproportionate share adjustment under the Medicaid utilization method established in Section V.(2), the Division shall divide the hospital's Medicaid utilization rate calculated pursuant to Section V.(2)(d) by the threshold Medicaid utilization rate calculated pursuant to Section V.(2)(c). The ratio resulting from such division is the federally-mandated disproportionate share ratio.

(b) For each hospital determined eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division shall set the hospital's federally-mandated disproportionate share ratio equal to one.

(c) The Division shall then determine, for the group of all eligible hospitals, the sum of federally-mandated disproportionate share ratios calculated pursuant to Section V.(4)(a) and Section V.(4)(b).

(d) The Division shall then calculate a minimum payment under the federally-mandated disproportionate share adjustment by dividing the amount of funds allocated pursuant to Section V.(5) for payments under the federally-mandated disproportionate share adjustment by the sum of the federally-mandated disproportionate share ratios calculated pursuant to Section V.(4)(c).

(e) The Division shall then multiply the minimum payment under the federally-mandated Medicaid disproportionate share adjustment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to Section V.(4)(a) and (b). Subject to the limits herein, the product of such multiplication is the payment under the federally-mandated disproportionate share adjustment.

(5) Allocation of Funds. The total amount of funds allocated for payment to non-acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement is one hundred fifty thousand dollars annually. These amounts is paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to Section V.(4)(e).

VI. Extraordinary Disproportionate Share Adjustment for Psychiatric Hospitals.

The Division shall determine an extraordinary disproportionate share adjustment for all eligible psychiatric hospitals, using the data and methodology described in Section VI.

(1) Data Sources.

The Division shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the disproportionate share adjustment to determine the cost, free care, charge, patient day, and net revenue amounts. If said DHCFP-403 report is not available, the Division shall use the most recent available previous DHCFP-403 report to estimate these variables. If the specified data source is unavailable, then the Division shall determine and use the best alternative data source.

(2) Determination of Eligibility.

(a) In order to be eligible for the extraordinary disproportionate share payment adjustment, a Psychiatric Hospital must:

1. specialize in providing psychiatric/psychological care and treatment;
2. provide for special active treatment such as treatment of deafness, developmental disabilities, and the elderly;
3. accept all patients without regard to their ability to pay;
4. consist partly or wholly of locked wards;
5. meet requirements for the receipt of federal matching funds;
6. meet the low-income standard as set forth in Section VI(2)(b); and
7. meet the unreimbursed cost standard as set forth in Section VI(2)(c).

(b) Low-income standard.

1. For each Psychiatric Hospital, the Division shall calculate the hospital-specific low-income utilization rate as follows:

   a. The Division shall divide each hospital's net Medicaid revenue by its total gross patient service revenue.
   b. The Division shall divide each hospital's free care GPSR by its total GPSR.
   c. The total of these percentages shall equal the hospital's low-income utilization rate.

2. If the hospital-specific low-income utilization rate exceeds 45%, then the Psychiatric Hospital meets the low-income standard.

(c) Unreimbursed cost standard.

1. For each Psychiatric Hospital, the Division shall calculate the hospital-specific unreimbursed cost percentage as follows:

a. The Division shall calculate the costs of providing hospital services to Medicaid-eligible individuals and uninsured individuals, by multiplying total Hospital costs by the ratio of Medicaid GPSR plus self pay GPSR plus free care GPSR to total GPSR.

b. The Division shall subtract the total of Medicaid payments (excluding any disproportionate share payments) plus self pay payments, from the costs determined in Section VI(2)(c)1.a., to determine the amount of unreimbursed costs.

c. The Division shall divide the amount of unreimbursed costs determined in Section VI(2)(c)1.b. by the costs determined in Section VI(2)(c)1.a. to determine the percentage of unreimbursed costs.

2. If the hospital-specific percentage of unreimbursed costs exceeds 50%, then the Psychiatric Hospital meets the unreimbursed cost standard.

(3) Determination of Payment. Subject to the limits herein, for each Psychiatric Hospital determined eligible for the extraordinary disproportionate share adjustment under Section VI(2), the payment amount is equal to the estimated rate year unreimbursed cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals, calculated as follows:

a. First, determine the estimated rate year cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals by determining the percentage of Medicaid, self-pay and Free Care GPSR to total Hospital GPSR. Rate Year cost is determined by multiplying the FY 1996 Public Assistance RFR approved by DHCFP pursuant to 114.1 CMR 40.00 by inflation factor of 4.31%. Then, multiply this cost by the unreimbursed cost percentage determined pursuant to Section VI(2)(c)1.c.

b. Limits on Allocation of Funds. The total amount of funds allocated for payment to psychiatric hospitals may be proportionately reduced to stay within the limits for disproportionate share payments for institutions for mental diseases (IMDs) reported by the Commonwealth to Health Care Financing Administration in accordance with limits pursuant to 42 U.S.C. 1396r-4.

Enclosure 3

Attachment 4.19 A(2b)

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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